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CHAPTER II
ANESTHESIA SERVICES
CPT CODES 00000-09999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter II
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A. Introduction

Anesthesia care conventionally includes all services associated with the administration of analgesia/anesthesia, provided by an anesthesiologist and/or certified registered nurse anesthetist (CRNA)[1] to a patient undergoing a surgical or other invasive procedure so that intervention can be undertaken. This may involve local, regional, epidural, general anesthesia or monitored anesthesia care (MAC), and usually involves administration of anxiolytics or amnesia-inducing medications. Additionally, anesthesia care includes preoperatively evaluating the patient with a sufficient history and physical examination so that the risk of adverse reactions can be minimized, planning alternative approaches to accomplishing anesthesia and answering all questions regarding the anesthesia procedure asked by the patient.

The anesthesiologist assumes responsibility for the post-anesthesia recovery period which is included in the anesthesia care package. It encompasses all care until the patient is released to the surgeon or another physician; this point of release generally occurs at the time of release from the post-anesthesia recovery area.

B. Standard Anesthesia Coding

The following policies reflect national Medicare correct coding guidelines for anesthesia services.

1. Principles of Medicare coding for anesthesia services involving administration of anesthesia are reported by the use of the anesthesia five-digit CPT procedure codes (00100-01860). These codes specify "Anesthesia for" followed by a general area of surgical intervention. Subsequent CPT codes (01905-01933) are unique to anesthesia for interventional radiology. Several CPT codes (01990-01999) describe miscellaneous anesthesia services.

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[1]In the following, the term CRNA is to be interpreted as including anesthesiologists' assistants.

Anesthesia services are provided by or under the supervision of a physician. These services may include, but are not limited to, general or regional anesthesia and monitoring of physiological parameters during local or peripheral block anesthesia with sedation (when medically necessary), or other supportive services in order to afford the patient anesthesia care deemed optimal by the anesthesiologist during any procedure.

Anesthesia codes describe a general anatomic area or service which usually relates to a number of surgical procedures, often from multiple sections of the *CPT Manual*. For Medicare purposes, only one anesthesia code is reported unless the anesthesia code is an add-on code. In this case, both the code for the primary anesthesia service and the anesthesia add-on code are reported according to *CPT Manual* instructions. It is acceptable to bill the code that accurately describes the anesthesia for the procedure which has the highest basic unit value.

2. Another unique characteristic of anesthesia coding is the reporting of time units for time spent delivering anesthesia. In contrast to some evaluation and management services which can be coded based on time, payment for anesthesia services varies with or increases with increments of time. In addition to billing a basic unit value for an anesthesia service, the units of service reflecting the time of anesthesia attendance are reported. Anesthesia time involves the continuous actual presence of the anesthesiologist and starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance, i.e., when the patient may be safely placed under postoperative supervision. Non-monitored interval time may not be considered for calculation of time units.

Example: A patient who undergoes a cataract extraction may require monitored anesthesia care (see below). This may require administration of a sedative in conjunction with a peri/retrobulbar injection for regional block anesthesia. Subsequently, an interval of 30 minutes or more may transpire during which time the patient does not require monitoring by an

anesthesiologist/certified registered nurse anesthetist. After this period, monitoring will commence again for the cataract extraction and ultimately the patient will be released to the surgeon's care or to recovery. The time that may be reported would include the time for the monitoring during the block and during the procedure. The interval time and the recovery time are not to be included in the time unit calculation. Also, if unusual services, not bundled into the anesthesia service, are required, the time spent delivering these services before anesthesia time begins or after it ends may not be included as reportable anesthesia time.

However, if it is medically necessary for the anesthesiologist/CRNA to be in direct one to one observation, monitoring the patient during the interval time, and not billing any other service, the time can be included.

3. It is standard medical practice for an anesthesiologist/CRNA to provide a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service. The time spent in performing the evaluation is included in the base unit of the code and therefore, is not included as anesthesia time. If surgery is canceled, either because of other circumstances or because of findings on the preoperative evaluation by the anesthesiologist and cancellation occurs subsequent to the preoperative evaluation, payment may be allowed to the anesthesiologist for an evaluation and management service and the appropriate E&M code (usually a consultation code) may be reported.

Similarly, routine postoperative evaluation is included in the basic unit for the anesthesia service. Additional time units would be inappropriate and evaluation and management codes are not to be used in addition to the anesthesia code. Postoperative evaluation and management services related to the surgery are not separately payable to the anesthesiologist except in the circumstance where the anesthesiologist is providing significant, separately identifiable services such as ongoing critical care services, postoperative pain management services, or extensive unrelated ventilator management. Management of epidural or subarachnoid drug administration (CPT code 01996) is separately payable on dates of service subsequent

to surgery but not on the date of surgery. If the only service provided is management of epidural/subarachnoid drug administration, then an evaluation and management service is not appropriate in addition to CPT code 01996. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day irrespective of the number of visits necessary to manage the catheter per postoperative day (CPT definition). While an anesthesiologist or CRNA may be able to bill for this service, only one payment will be made per day. Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesiologist unless separate, medically necessary services are required that cannot be rendered by the surgeon. The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesiologist.

In certain circumstances critical care services are provided by the anesthesiologist. It is currently national CMS policy that CRNAs cannot be reimbursed for evaluation and management services in the critical care area. In the case of anesthesiologists, the routine immediate postoperative care is not separately reported except as described above. Procedural services such as placement of lines, emergency intubation (outside of the operating suite), etc. are payable to anesthesiologists as well as CRNAs if these procedures are furnished within the parameters of appropriate state licensing laws.

4. Anesthesia HCPCS/CPT codes include all services integral to the anesthesia procedure such as preparation, monitoring, intra-operative care, and post-operative care until the patient is released by the anesthesiologist to the care of another physician. Examples of integral services include, but are not limited to, the following:

- Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.

- Placement of external devices necessary for cardiac monitoring, oximetry, capnography, temperature, EEG, CNS evoked responses (e.g., BSER), doppler flow.
- Placement of peripheral intravenous lines necessary for fluid and medication administration.
- Placement of airway (endotracheal tube, orotracheal tube, etc.).
- Laryngoscopy (direct or endoscopically) for placement of airway (endotracheal tube, etc.).
- Placement of naso-gastric or oro-gastric tube.
- Intra-operative interpretation of monitored functions (blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).
- Interpretation of laboratory determinations (arterial blood gases such as pH, pO_2, pCO_2, bicarbonate, hematology, blood chemistries, lactate, etc.) by the anesthesiologist/CRNA.
- Nerve stimulation for determination of level of paralysis or localization of nerve(s). (Codes for EMG services are for diagnostic purposes for nerve dysfunction. To report these codes a complete diagnostic report must be present in the medical record.)
- Insertion of urinary bladder catheter
- Blood sample procurement through existing lines or requiring only venipuncture or arterial puncture.

The NCCI contains many edits bundling standard preparation, monitoring, and procedural services into anesthesia CPT codes. Although some of these services may never be reported on the same date of service as an anesthesia service, many of these services could be provided at a separate patient encounter unrelated to the anesthesia service on the same date of service.

Providers may utilize modifier -59 to bypass the edits under these circumstances.

CPT codes describing services that are integral to an anesthesia service include but are not limited to, the following:

- 31505, 31515, 31527 (Laryngoscopy) (Laryngoscopy codes are for diagnostic or surgical services)
- 31622, 31645, 31646 (Bronchoscopy)
- 36000 - 36015 (Introduction of needle or catheter)
- 36400-36440 (Venipuncture and transfusion)
- Blood sample procurement through existing lines or requiring only venipuncture or arterial puncture.
- 62310-62311, 62318-62319 (Injection of diagnostic or therapeutic substance):
  CPT codes 62310-62311 and 62318-62319 may be reported on the date of surgery if performed for postoperative pain relief rather than as the means for providing the regional block for the surgical procedure. If a narcotic or other analgesic is injected through the same catheter as the anesthetic, CPT codes 62310-62319 should not be billed. Modifier -59 will indicate that the injection was performed for postoperative pain relief but a procedure note should be included in the medical record.

  Example: A patient has an epidural block with sedation and monitoring for arthroscopic knee surgery. The anesthesiologist reports CPT code 01382 (Anesthesia for diagnostic arthroscopic procedures of knee joint). The epidural catheter is left in place for postoperative pain management. The anesthesiologist should not also report CPT codes 62311 (injection of diagnostic or therapeutic substance) or 01996 (daily management of epidural) on the date of surgery. CPT code 01996 may be reported with one unit of service per day on subsequent days until the catheter is removed. On the other hand, if the anesthesiologist

performed general anesthesia reported as CPT code 01382 and reasonably believes that postoperative pain is likely to be sufficient to warrant an epidural catheter, CPT code 62319-59 may be reported indicating that this is a separate service from the anesthesia service. In this instance, the service is separately payable whether the catheter is placed before, during, or after the surgery. If the epidural catheter was placed on a different date than the surgery, modifier -59 would not be necessary. Effective January 1, 2004, daily hospital management of continuous epidural or subarachnoid drug administration performed on the day(s) subsequent to the placement of an epidural or subarachnoid catheter (CPT codes 62318-62319) may be reported as CPT code 01996.

- 64400-64565 (Nerve blocks)
- 67500 (Retrobulbar injection)
- 81000-81015, 82013, 82205, 82270, 82271(Performance and interpretation of laboratory tests)
- 90760-90775 (Injections, IV infusions, and drug administration)
- 91000, 91055, 91105 (Esophageal, gastric intubation)
- 92511-92520, 92543 (Special otorhinolaryngologic services)
- 92950 (Cardiopulmonary resuscitation)
- 92953 (Temporary transcutaneous pacemaker)
- 92960 (Cardioversion)
- 93000-93010 (Electrocardiography)
- 93015-93018 (Cardiovascular stress tests)
- 93040-93042 (Electrocardiography)
- 93307-93308 (Transthoracic echocardiography when displayed for monitoring purposes.) However, when

performed for diagnostic purposes with documentation of a formal report, this service will be considered a significant, separately identifiable, and separately payable service.

- 93312-93317 (Transesophageal echocardiography) However, when performed for diagnostic purposes with documentation of a formal report, this service will be considered a significant, separately identifiable, and separately payable service.

- 93318 (Transesophageal echocardiography for monitoring purposes)

- 93922-93981 (Extremity arterial venous studies) When performed diagnostically with a formal report, this will be considered a significant, separately identifiable, and if medically necessary, a payable service.

- 94640(Inhalation/IPPB treatments)

- 94656, 94660-94662 (Ventilation management/CPAP services) If performed as management for maintenance ventilation during a surgical procedure, this is part of the anesthesia service. This is separately payable if performed as an ongoing service after transfer out of the operating room or post-anesthesia recovery to a hospital unit/ICU. Modifier -59 would be necessary to signify that this was a separate service.

- 94664 (Inhalations)

- 94680-94690 (Expired gas analysis)

- 94760-94770 (Oximetry)

- 99201-99499 (Evaluation and management)

(This is not a comprehensive list of all services included in anesthesia services.)

C. Radiologic Anesthesia Coding

In keeping with standard anesthesia billing guidelines for Medicare, only one anesthesia code may be reported for anesthesia services provided in conjunction with radiological procedures. Radiological Supervision and Interpretation (S & I) codes will usually be applicable to radiological procedures being performed.

The appropriate S & I code may be reported by the appropriate provider (radiologist, cardiologist, neurosurgeon, radiation oncologist, etc.). Accordingly, S & I codes are not included in anesthesia codes referable to these procedures; only the appropriate provider, however, may bill for S & I services.

CPT code 01920 (Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter) can be reported for monitored anesthesia care (MAC) in patients who are critically ill or critically unstable. If the physician performing the radiologic service places a catheter as part of that service, and, through the same site, a catheter is left and used for monitoring purposes, it is inappropriate for either the anesthesiologist/certified registered nurse anesthetist or the physician performing the radiologic procedure to bill for placement of the monitoring catheter (e.g., CPT codes 36500, 36555-36556, 36568-36569, 36580, 36584, 36597).

D. Monitored Anesthesia Care (MAC)

There has been a shift to providing more surgical and diagnostic services in an ambulatory, outpatient or office setting. Accompanying this, there has also been a change in the provision of anesthesia services from traditional general anesthetic to a combination of local or regional anesthetic with certain conscious altering drugs. This type of anesthesia is referred to as monitored anesthesia care if provided directly by a physician or anesthesiologist or by a medically-directed CRNA. In essence, MAC involves patient monitoring sufficient to anticipate the potential need to administer general anesthesia during a surgical or other procedure. MAC requires careful and continuous evaluation of various vital physiologic functions and

the recognition and treatment of any adverse changes. CMS recognizes this type of anesthesia service as a payable service if medically necessary and reasonable.

Because monitored anesthesia care (MAC) requires at least the same level of monitoring as that of general anesthesia, it is treated the same as general anesthesia except that the appropriate modifiers must be used for payment purposes. The guidelines as promulgated previously apply equally to MAC. It is particularly important to note that Medicare policy allows only one anesthesia CPT code to be reported, and the time units reported represent only time where the patient was continuously monitored by a physician or anesthesiologist (personally, or a CRNA.) Preoperative and postoperative assessments follow standard anesthesia billing guidelines.

Issues of medical necessity are addressed by National and Local Contractor Medical Review Policy.

E. Anesthesiologists and CRNAs

CMS recognizes the services of anesthesiologists as providers and physicians in a supervisory capacity. Anesthesiologists personally performing anesthesia services bill in a standard fashion, in accordance with CMS regulations as outlined in the *Medicare Carriers' Manual* Sections §4137 or *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 50, MCM §4830 or *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12 Sections 40.1A, 40.1D, 50E, 50K, 140.2, MCM §15018 or *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Sections 50, 50K, 140.3.2. CMS also recognizes CRNAs and anesthesiologists' assistants practicing under the medical direction of anesthesiologists or practicing independently of anesthesiologists. Billing instructions and regulations regarding this arrangement are outlined in the *Medicare Carriers' Manual* as noted above and in Section §16003 or *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Sections 140, 140.1, 140.2, 140.3, 140.3.1, 140.4.3, 140.4.4.

F. General Policy Statements

1. In this Manual many policies are described utilizing the term "physician". Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term "physician" would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. Physicians should not report drug administration HCPCS/CPT codes 90760-90775 and C8950-C8952 for anesthetic agents or other drugs administered between the patient's arrival at the operative center and discharge from the post-anesthesia care unit.

3. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*